Introduction

Dual-process theories (Epstein, 1994) suggest that cognition can be categorised into two key types:

- **Explicit**: rational, conscious & effortful
  - Measured through self-report
- **Implicit**: automatic, intuitive, effortless
  - Measured through reaction-time measures (computerised tasks, such as the Implicit Association Test); these assess relative association strengths between the target concepts and valence stimuli.

Self-reported low self-esteem is common in:
- Eating disorders (risk + maintenance factor) &
- Restrained eaters (chronic dieters)

**BUT**! It seems that implicit self-esteem in people with elevated eating disorder (ED) pathology is just as high when compared to healthy controls:
- Vanderlinden et al. (2009): in anorexia/bulimia
- Cockermach et al. (2009): in bulimia/binge eating disorder
- Hoffmeister et al. (2010); in restrained eaters

SO: Research suggests that elevated ED symptoms (both at clinical and pre-clinical level) are associated with discrepant self-esteem: i.e., low explicit vs. high implicit.

But why? Studies suggest the discrepancy might be associated with restraint (Hoffmeister et al., 2010); but not body dissatisfaction (Svaldi et al., 2012). Does the distinction extend to other domains of the pathology?

**Aims**

- Replicate previous findings which suggest that elevated ED pathology is associated with discrepant (low explicit, high implicit) self-esteem
- Determine which specific aspects of ED symptomatology are associated with this discrepancy: a) dietary restraint, b) eating concern, c) shape concern and/or d) weight concern.

Method

**Participants**: 79 women, ten excluded for failing to reach minimum accuracy criteria on the IAT. Age M=22.43, BMI M=21.60. Six participants had been diagnosed with an ED in their life time, but excluding their data did not affect the results.

**Measures**:
- Self-esteem Implicit Association Test (IAT): implicit self-esteem
- Rosenberg Self-Esteem scale (RSE): explicit self-esteem
- Eating Disorder Examination Questionnaire (EDE-Q): ED symptomatology
- Participants were split into high- and low-symptom groups via median split for the four EDE-Q subscales: dietary restraint, eating concern, weight concern and shape concern.

**Procedure**: Participants completed a) the questionnaires, b) the IAT and c) height and weight measurements in a randomised order.

References


Results

- **Previous findings replicated**: Participants scoring high on the EDE-Q had significantly lower explicit, F(1,67)=12.38, p<.001, but not implicit, F(1,67)=1.55, ns., self-esteem compared with those scoring low. The scale-specific results are below:

  - **Associated with dietary restraint and eating concern**
  - **Not associated with weight concern or shape concern**

Discussion

The current study lends further support to the association between self-esteem discrepancy and elevated (but pre-clinical) levels of ED pathology:

- Participants who reported high dietary restraint or eating concern reported discrepant self-esteem: low explicit + high implicit.
- Participants who reported high concern with their weight or shape had consistently low self-esteem: low explicit + low implicit.

**WHY?**

- Implicit self-esteem increases in response to ego threat?
  - Not supported empirically
- Discrepant self-esteem is broadly suggests psychological distress?
  - Not informative enough
- "Glimmer of hope" (Spencer et al., 2005)?
  - Possible!
- People who have high implicit, despite low explicit, self-esteem may be motivated to reconcile that discrepancy through weight loss (lose weight feel better about yourself)
- People who have low implicit and explicit self-esteem may be dissatisfied with their weight or body shape, but will feel less compelled to change.

**Future studies are needed to replicate the results with a broader scope of pathology, as well as generalise the findings to a clinical context. The results have implications for cognitive models of disordered eating and possible practical applications in screening.**

Conclusions

- Discrepant self-esteem was associated with food concern but not dietary concern
- Food concern at sub-clinical levels may therefore reflect an attempt to reconcile this self-esteem discrepancy